

Application for Single Premium Life Insurance and Annuity

I. Proposed Insured and Beneficiary Information

Last Name		First Name				MI	
Social Security Number	Age	Sex	Date of Birth	State or Country of Birth	Height	Weight	
Telephone: Day	Evening			Email Address			
Street Address			City	State	Zip Code		
Primary Beneficiary			Social Security Number	Relationship to Proposed Insured			
Contingent Beneficiary			Social Security Number	Relationship to Proposed Insured			

2. Owner (if other than Proposed Insured)

Last Name	First Name	MI	Date of Birth	Tax ID# or Social Security#	Relationship to Proposed Insured		
Street Address		City	State	Zip Code			

3. Insurance Product and Riders Applied For

Product _____ Face Amount \$ _____ Premium Amount \$ _____

Accelerated Death Benefit Rider *Included (if available) unless you check "No" here* No Other Rider _____

4. Medical Questions

Part 1

1. To the best of your knowledge and belief have you, the Proposed Insured, ever been:
 - a. diagnosed with a terminal illness, receive kidney dialysis, or told you have dementia/Alzheimer's? Yes No
 - b. diagnosed by or received treatment from a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system? Yes No
2. Are you currently bedridden at home, confined in a hospital, nursing home, hospice, assisted living or long term care facility, use oxygen or recommended to use oxygen, or require the use of a wheelchair due to chronic illness? Yes No

Part 2

1. Has the proposed insured had an application for life or health insurance or reinstatement declined, rated or modified in any way? Yes No
2. Has the proposed insured:
 - a. been hospitalized or consulted a physician for any reason during the past 5 years? Yes No
 - b. ever been told he/she had, or ever been treated for cancer; kidney disease, diabetes, leukemia, multiple sclerosis, paralysis, fainting, chest pains, angina, congestive heart failure, or other disease of the heart or blood vessels, lung or liver disease, emphysema, bronchitis, stroke or high blood pressure, mental or nervous disorder or drug or alcohol abuse? Yes No
3. Is the proposed insured currently taking any medication or treatment prescribed by a physician or other medical professional? Yes No
4. Has the proposed insured used tobacco or nicotine in the past 12 months? Yes No

Please provide details of all "Yes" answers from Section 4 in the area below. (Use Comments section if additional space is needed.)

Question #	Explanation	Dates/Duration	Name of Medical Professional

Comments

(Attach a separate sheet if more space is needed.)

5. Annuity Information

In the event I do not qualify for the life insurance applied for, Baltimore Life is authorized to apply all monies received with this application to the purchase of a Single Premium Deferred Annuity Yes No

If "Yes", this application will also serve as the application for the annuity. The beneficiary and owner will be as indicated above. The proposed insured will be the annuitant. The Maturity Date will be the next contract anniversary following age 95 of the annuitant, unless a different date is specified here: _____

Annuity: _____ Interest Guarantee Period: _____

6. Replacement Information

a. Do you have any existing life insurance or annuities currently in force or pending with this or any other company? Yes No

b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company? Yes No

If "Yes," provide the following information:

Name of Company _____ Policy No. _____

Why is replacement occurring? _____

7. Agent Certification

To be completed by agent. I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification? Yes No

b. Do you have knowledge or reason to believe that replacement of existing life insurance or annuity policies may be involved? Yes No

c. If replacement is occurring, do you certify that this replacement complies with Baltimore Life's replacement guidelines? Yes No Not Applicable

I certify that only advertising previously approved by The Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery.

I certify that the above statements and responses are true and accurate.

Print Agent's Name Agent Number (X) _____ Agent Signature _____ Date

Split Credit

If more than one agent is to receive split credit for this case, please complete the information below. Please Print.

Split Agent 2 _____ Agent No. _____ % _____ of split credits

Split Agent 3 _____ Agent No. _____ % _____ of split credits

8. Declarations and Authorizations

It is understood that The Baltimore Life Insurance Company (the Company) has the right to require a medical examination. If so, this application is not complete until the medical examination has been performed.

AGREEMENT: I have read or had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

It is understood that the President, a Vice President, or the Secretary must sign all agreements made by the Company. No other person, including an insurance agent or broker, can change the terms of any policy or make any promise or agreement binding on the Company.

Except as may be provided by the Conditional Receipt bearing the same date and form number as this application, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while each person proposed for coverage is alive and continues to be insurable, and whose condition of health and occupation, as described in this application, are unchanged from the date of the application.
2. The required premium is paid in full to The Baltimore Life Insurance Company, and the application is approved and accepted by the Company.

AUTHORIZATION AND ACKNOWLEDGMENT: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility or health care provider; insurance or reinsuring company, or the Medical Information Bureau, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment, prescriptions and/or prognosis of me with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other nonmedical information about me to give to the Company any and all such information. I understand the information obtained by use of this authorization will be used by the Company to determine eligibility for insurance and/or benefits. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original.

This authorization shall remain valid for a period of two years and six months from the date it is signed. I acknowledge receipt of the Medical Information Bureau, Inc. Pre-Notice and the Fair Credit Reporting Act Notice.

ACCELERATED DEATH BENEFIT TAX DISCLOSURE: The receipt of a benefit under the Accelerated Death Benefit Rider may be taxable. Before claiming a benefit under this Rider, assistance should be sought from a personal tax advisor.

IMPORTANT TAX NOTICE FOR POLICYOWNER: Under federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

Certification: Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2) I am not subject to backup withholding under provisions of section 3406(a)(1)(c) of the Internal Revenue Code because a) I am exempt from backup withholding, or b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a US person (including a US resident alien).

The Internal Revenue Service does not require your consent to any provisions to this document other than the certification to avoid backup withholding.

I certify that I have read the medical questions contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

If replacement is occurring, please read the following notice: In many cases, the replacement of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement you are considering.

If you are replacing an existing policy and you are not satisfied with the new policy for any reason, you have the right to return your policy to us within 30 days after you receive it and receive a refund of all premiums paid.

Application made at _____ this _____ day of _____, _____
(City, State) (Day) (Month) (Year)

(X) _____
Signature of Proposed Insured

(X) _____
Signature of Owner (If other than Proposed Insured)

(X) _____
Signature of Licensed Agent (Witness to all signatures)

(Give official capacity if signed on behalf of a corporation, trust etc.)

Conditional Receipt

(This receipt must not be detached unless the full initial premium has been deposited at the time of application)

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY AND ACCEPTANCE UNLESS THE FOLLOWING CONDITIONS REQUIRED BY THIS RECEIPT ARE MET:

- a. The full initial premium is paid according to the method of premium payment selected in the application for the amount of insurance applied for;
- b. Any check given or draft authorized for premium payment is honored when first presented for payment;
- c. All medical examinations, tests, X-rays and electrocardiograms required by the Company's underwriting rules and standards are completed within 60 days from the date of the application;
- d. The Proposed Insured is, on the date of application and continuing until the policy is delivered, an insurable risk under the Company's rules, limits and standards as to plan, benefits, class, and amount for the policy applied for;
- e. The application is approved by the Company; and
- f. There is no material misrepresentation in the application or medical information furnished to the Company.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE PREMIUM PAYMENT. Subject to satisfactory completion of all of the above conditions, the effective date of coverage provided by receipt will be the later of: (1) the date of the application; (2) the date of the last of any medical examinations or tests required under the Company's underwriting rules and practices; or (3) the date, if any, requested in the application. Once coverage under this receipt becomes effective, the maximum death benefit and all other supplemental benefits provided by this receipt will be the lesser of: a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with the Company or b) \$150,000. Either the Company or the proposed insured or owner, as applicable, may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application. If the Company declines to issue a policy or issues a policy other than as applied for which is not accepted, the premium payment will be refunded. There will be no liability on account of this receipt if any premium check or draft is not honored upon presentation for payment. If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment. If the proposed insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment. No broker, agent or medical examiner is authorized to accept risks or pass on insurability, make or alter any contract, waive a complete answer to any question in the application, waive any conditions under this receipt or waive any of the Company's rights or requirements or otherwise bind the Company in any way by any promise or statement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received \$ _____ from _____ for an application on _____
Dated _____.

Signature of Proposed Insured

Signature of Proposed Owner (If other than Proposed Insured)

Signature of Agent

Tear here and leave notices below with Applicant

Fair Credit Reporting Act Notice

As part of our evaluation of your application for insurance, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

Medical Information Bureau, Inc. Notice

Information regarding your insurability will be treated as confidential. The Baltimore Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112; the telephone number is (617) 426-3660.

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.